Self-Management Support Tool

Healthy Changes Plan
Health Care Provider: ________________________________

Name: ___________________________ Date: ___________ Phone: ________________________________

The healthy change I want to make is (very specific: What, When, How, Where, How Often):

____________________________________________________________________________________

My goal for the next month is:

____________________________________________________________________________________

The steps I will take to achieve my goal are:

____________________________________________________________________________________

The things that could make it difficult to achieve my goal include:

____________________________________________________________________________________

My plan for overcoming these difficulties includes:

____________________________________________________________________________________

Support/resources I will need to achieve my goal include:

____________________________________________________________________________________

My confidence that I can achieve my goal: (scale of 1–10 with 1 being not confident at all, 10 being extremely confident)

____________________________________________________________________________________

Review date: ___________________________ with ________________________________